U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

March 8, 2019

TO: Republican Members

FROM: Republican Committee Staff

RE: Hearing entitled "The Fiscal Year 2020 HHS Budget"

I. INTRODUCTION

The Subcommittee on Health will hold a hearing on Tuesday, March 12, 2019, at 12:00 p.m. in 2123 Rayburn House Office Building. The hearing is entitled "The Fiscal Year 2020 HHS Budget."

II. REPUBLICAN WITNESS

- The Honorable Alex Michael Azar II, Secretary of the United States Department of Health and Human Services.

III. BACKGROUND

The FY 2020 budget is expected to be released on Monday, March 11, 2019. This memo outlines issues the Democrats will likely use to attack the Secretary. A supplemental memo highlighting policies reflected in the Budget will be available as soon as it is available.

Five percent cuts to discretionary health spending:

- According to the Government Accountability Office, the growth in mandatory spending crowds out resources for discretionary spending. The careful management of agency budgets is necessary to ensuring that they can continue to achieve their missions and deliver services to the public.[1] Recognizing the importance of controlling excessive spending, the President directed non-defense agencies to identify how they can cut a nickel out of every dollar they spend. This would be one of the largest spending reductions in history. But just as American families are forced to prioritize their spending, the Federal government can do the same. Within these constrained levels, agencies are still able to provide investments in key national priorities.

The handling of unaccompanied alien children:

In April 2018, the Department of Justice (DOJ) announced a "Zero Tolerance" initiative, which called for the prosecution of all individuals who illegally enter the United States. As minors cannot be held in criminal detention facilities, the policy had the effect of separating

[1] https://www.gao.gov/key_issues/federal_budgeting/issue_summary

parents or legal guardians prosecuted by DOJ from their children when they illegally entered the country together.

When a parent or legal guardian traveling with their child is referred for prosecution, the Department of Homeland Security (DHS) separates the child from his or her parent or legal guardian, and the child is cared for by the Office of Refugee Resettlement (ORR) at the Department of Health and Human Services (HHS). Outside of the separations that occurred during the "Zero Tolerance" initiative, DHS will separate a child from a parent or legal guardian who is referred for prosecution or poses a safety risk to the child and will also separate a child from an adult who is not the child's parent or legal guardian.

ORR is typically responsible for caring for unaccompanied alien children (UAC) from non-contiguous countries until they are placed with a sponsor, who is often a parent or other family member. If a sponsor cannot be located, then ORR will care for the child while they await an immigration hearing. ORR provides extensive services, including medical and mental health services, to the UAC in its care.

The Committee has conducted oversight of ORR and issues related to UAC since 2014, when there was a surge of UAC crossing the Southwest border. At that time, the Committee identified concerns regarding the treatment of the children, as well as inadequate policies and procedures for the program to ensure the safety and well-being of all UAC. As a result of the Committee's oversight, improvements were made to the program, including more robust medical treatment and increased background checks.

- The Committee does NOT have legislative jurisdiction over ORR or immigration policy.

- Republicans on the Committee have conducted oversight of ORR and issues related to UAC since 2014, when HHS and the Obama Administration were completely unprepared to care for the thousands of UAC who came across the border that summer.

- The Committee continued this work after we learned of the family separations at the border, including a bipartisan delegation of Members going to the border, a briefing for Members in the Secretary's Operation Center at HHS – the hub of the reunification effort, and a letter from all Republican Members to HHS.

- It is important to distinguish between the various roles and responsibilities as it relates to UAC and the family separations and reunifications. HHS is an important piece of this, but it is by no means the entire picture. Any meaningful oversight and inquiries must include representation from DOJ and DHS.

- All of the Committee's Republican Members sent a letter to HHS on June 29, 2018, regarding the ORR program and the management, treatment, and reunification of unaccompanied alien children.

- The letter followed the adoption of an amendment at a June 2018 Health Subcommittee markup. The amendment, which passed by a unanimous 29-0 vote, required weekly

reports to the Committee and a formal strategy regarding HHS' efforts to reunite these children with their families, in addition to addressing challenges previously identified by the Committee.

- On July 9, 2018, Chairman Walden led a bipartisan delegation of Committee Members to McAllen, Texas, and surrounding areas, to view border facilities. While the delegation visited a variety of sites pertaining to our country's immigration system, the focus was on the Department of Health and Human Services' (HHS') Office of Refugee Resettlement (ORR).

- At a markup in July 2018, the Committee considered a Resolution of Inquiry (ROI) introduced by then-Ranking Member Frank Pallone, Jr. (D-NJ). An ROI is a tool typically used by the minority when the Administration has not provided information to them. As then-Chairman Walden noted at the time, HHS had responded to information requests from both Mr. Pallone and Mr. Walden. Because the Committee's investigation was ongoing, dating back to 2014 under the Obama Administration, the Committee voted 52-0 to report the resolution of inquiry without recommendation.

- In 2018, Committee staff visited six ORR-funded facilities in Texas, Virginia, and Maryland, including the Tornillo facility.

- At a February 2019 Oversight and Investigations Subcommittee hearing, career HHS official Commander Jonathan White of the U.S. Public Health Service made clear that HHS played no role in implementing the family separation policy. The role of HHS was to care for and place the children while other agencies carried out immigration legal proceedings. Commander White had raised concerns about separating families apprehended at the border to three Administration appointees before the policy was even announced.

- Axios recently reported that between October 2014 and July 2018, the ORR reports that it received 4,556 complaints of sexual abuse of UAC.[2] Additionally, the Department of Justice (DOJ) reported receiving 1,303 sexual abuse of unaccompanied minors complaints. Most of the complaints were allegedly carried out at the hands of other unaccompanied minors. DOJ officials reported 178 of those cases were by adult staff.

- Employees of migrant shelters are NOT HHS employees. HHS contracts with over 100 shelters across the country. Every shelter that the agency operates is independently licensed by the State where it is located.

The Administration's changes to Title X Family Planning Program:

Established in 1970, Title X is the only Federal program dedicated solely to the provision of family planning and related preventive services, with priority given to low income patients.

[2] https://www.axios.com/immigration-unaccompanied-minors-sexual-assault-3222e230-29e1-430f-a361-d959c88c5d8c.html

The program provides funding "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents)."[3] Pursuant to Congressional mandate, family participation is encouraged, particularly in services involving adolescents, and Title X funds cannot be used to support abortion.[4] The regulations governing the Title X program have not been substantially updated since 2000. On February 22, 2019, HHS issued a final rule to revise the regulations governing the Title X family planning program. According to HHS, the final rule ensures compliance with statutory prohibition against using Title X funds for programs where abortion is a method of family planning. According to a recent Marist poll, the majority of Americans oppose taxpayer funding for abortions.[5] Abortion providers who do not comply with the new regulations will not be eligible for Title X funds. The rule does not reduce Title X funds; it redirects them to providers that do not perform or promote abortions. Some of the more notable provisions in the final rule are:

- Removes the requirement that family planning providers must offer abortion referrals;
- Prohibits family planning providers from referring patients for abortions;
- Permits, but no longer requires providers to give women with unintended pregnancies "nondirective" counseling about all their options, which means that providers neither encourage nor deter women from any specific action (from pregnancy counseling to abortions);
- Requires referrals for those conditions deemed medically necessary, such as referral for prenatal care;
- Requires family planning providers that perform abortions or offer abortion referrals to physically and financially separate their abortion facilities from the rest of the family planning clinic – this includes physical and financial separation of facilities, services, personnel and records. When the rule goes into effect, grantees will have one year to achieve physical separation and 120 days to achieve financial separation;
- Requires compliance with all State and local laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape, incest, intimate partner violence, or human trafficking; and
- Officially revokes a 2016 regulation that limited the ability of States and other Title X grantees to exercise flexibility in choosing their subrecipients. The 2016 regulation had been rendered void by a joint resolution of disapproval passed by Congress under the Congressional Review Act and signed by the President.

A coalition of 20 States along with the State of California have separately announced lawsuits seeking a court injunction to stop the rule from taking effect in 60 days. Opponents of the final rule say it will effectively cut off tens of millions of Federal family planning dollars to Planned Parenthood and steer some of that funding towards pro-life, faith-based care providers.

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[3] PHS Act § 1001(a), 42 U.S.C. § 300(a).
[4] "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning." PHS Act § 1008, 42 U.S.C. § 300a-6.
[5] http://www.kofc.org/en/news/polls/abortion-restrictions-supported.html?fbclid=IwAR1fy9ydeT57ogT1NIvphUaN_wj7dRQawrbLCOs9Fw16LczA62TbD2UiPfg

They argue that the provision barring providers from discussing abortion violates provision of the Patient Protection Affordable Care Act (PPACA) requiring the full disclosure of all relevant information needed to make healthcare decisions. Opponents also argue the rule violates a provision from Congress saying all pregnancy counseling provided using Title X funding must be "non-directive" and not push patients to one option or another.

This rule is not the first time HHS has withheld Federal family planning funds from organizations that provide abortions. Ending abortion referral and requiring the physical and financial separation of abortion activities within a program were part of regulations promulgated under President Ronald Reagan in 1988 and upheld by the Supreme Court in 1991, during the Bush Administration.[6] However, the rule was never implemented and was swiftly eliminated by the Clinton Administration.

Medicaid work requirements:

We expect Democrats to contend that the Trump Administration's efforts to incentivize community engagement among able-bodied, working-age Medicaid beneficiaries will restrict access to health care services and harm the health of millions of Americans. They will also contend that by granting these approvals, the Administration is violating the intent of section 1115 of the Social Security Act.

However, the policy is limited in scope, and is a response to numerous State requests to test programs through Medicaid demonstration projects under which work or participation in other community engagement activities – including skills training, education, job search, volunteering or caregiving – would be a condition for Medicaid eligibility for able-bodied, working-age adults. This would exclude individuals eligible for Medicaid due to a disability, elderly beneficiaries, children, and pregnant women.

This is not a Federal mandate. It is a response from States who are seeking ways to innovate and update their Medicaid programs. The Centers for Medicare and Medicaid Services (CMS) has received demonstration project proposals from 10 States that include employment and community engagement initiatives: Arizona, Arkansas, Indiana, Kansas, Kentucky, Maine, New Hampshire, North Carolina, Utah, and Wisconsin. There are also important protections that will be required from States as they implement this policy.

Meeting work and community engagement requirements should take into consideration areas of high unemployment or caregiving for young children or elderly family members. States will therefore be required to describe strategies to assist eligible individuals in meeting work and community engagement requirements and to link individuals to additional resources for job training, provided they do not use Federal Medicaid funding to finance these services.

The Administration has also worked to support State efforts to align Medicaid work and community engagement requirements with Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) requirements, where appropriate, as part of

[6] Rust v. Sullivan, 500 U.S. 173 (1991)

this demonstration opportunity. Aligning requirements across these programs may streamline eligibility and reduce burdens on both States and beneficiaries, and help beneficiaries succeed in meeting their work and community engagement responsibilities.

States must also fully comply with Federal disability and civil rights laws and ensure that all individuals with disabilities have the necessary protections to ensure that they are not inappropriately denied coverage. States will be required to offer reasonable modifications to individuals with disabilities, and exempt individuals who are medically frail or have an acute condition that prevents them from complying with the requirements.

The Administration also encourages States to consider a range of activities that could satisfy work and community engagement requirements. States should ensure that career planning, job training, referral, and volunteering opportunities considered to meet the community engagement requirement, and job support services offered in connection with the requirement, take into account people's employability and potential contributions to the labor market.

Section 1115 of the Social Security Act gives the HHS Secretary the authority to approve experimental, pilot, or demonstration projects determined by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. Demonstrations, which give States additional flexibility to design and improve their programs, are also designed to evaluate state-specific policy approaches and better serve Medicaid populations. The Administration contends that State reform strategies under section 1115 should align with a core objective of the Medicaid program: "serving the health and wellness needs of the nation's vulnerable and low-income individuals and families." Research has shown that when people go back to work after work requirements are implemented, their incomes double or triple in just a year or two. Getting these able-bodied adults back to work also frees up resources for the truly needy — the very people that the Medicaid program was designed to help.

Administration efforts to reform Medicaid:

The Democrats will charge that the Budget "continues the assault on working families by cutting Medicaid." Democrats believe that per capita caps or block grants or efforts to provide States flexibility to manage their program will take coverage away from families that depend on Medicaid. They will charge that the Administration's Budget will "gut the single largest insurer of children in the United States, institute an unprecedented cut on the largest payer for behavioral health, and dangerously jeopardize care for seniors in nursing homes, individuals with disabilities, and working families."

We do not accept their premise that modernizing the Medicaid program means the program should be dismantled. Medicaid is a critical safety net for of our nation's most vulnerable citizens, including children, pregnant mothers, elderly individuals, blind individuals, and individuals with disabilities.

Medicaid is the world's largest health insurance program covering approximately 76 million Americans—more than Medicare —and up to 97 million may be covered at any one point in a given year.[7]

Medicaid is jointly funded by Federal and State governments. According to the Congressional Budget Office, Federal Medicaid outlays are expected to increase dramatically over the coming decade, from $383 billion in 2018 to $655 billion in 2028.[8] Today, Medicaid is one of the fastest growing spending items for States and accounted for more than 29 percent of State spending in FY 2018, according to the National Association of State Budget Officers.[9] This portion of State budgets devoted to Medicaid has grown over time, and has accelerated in recent years. Spending from State funds alone increased by 4.8 from 2017 to 2018, and now accounts for 58.3 percent of State funding from Federal funds.[10] As these numbers suggest, the Medicaid safety net is under strain.

State Medicaid programs have also suffered from significant waste, fraud, and abuse due to failures in State and Federal oversight.[11] The Government Accountability Office, for example, found that Medicaid made more than $36 billion in improper payments in 2017.[12] On its current path, the Medicaid program is on unsustainable financial footing. This is not merely a fiscal issue, but an issue that jeopardizes the ability of the Federal and State government to take care of the most vulnerable who rely on the program.

With the Medicaid program facing increased demands and with Federal outlays continuing to climb, we should be looking at a range of policies that will further the goals of empowering States, improving access, prioritizing vulnerable patients, improving health outcomes, modernizing outdated and inefficient rules, increasing efficiency, and putting Federal Medicaid spending on a more sustainable path. As the National Association of Medicaid Directors explained, "there are meaningful opportunities for [F]ederal policymakers to support [S]tates in working towards . . . shared goals, including by making targeted reforms to antiquated [F]ederal statute and regulations. Too many of the [F]ederal policies in place today are legacies from the last century. They do not reflect the current realities for running a Medicaid program nor do they align with the vision for Medicaid and the broader health care system."[13]

Medicaid Per Capita Caps or Block Grants:

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[7] See the Congressional Budget Office's Medicaid baseline, available online here: https://www.cbo.gov/system/files?file=2018-06/51301-2018-04-medicaid.pdf
[8] See the Congressional Budget Office's Medicaid baseline, available online here: https://www.cbo.gov/system/files?file=2018-06/51301-2018-04-medicaid.pdf
[9] See the National Association of State Budget Officers, State Expenditure Report, available online here: https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2018_State_Expenditure_Report_S.pdf
[10] See the National Association of State Budget Officers, State Expenditure Report, available online here: https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2018_State_Expenditure_Report_S.pdf
[11] www.ncsl.org/research/health/medicaid-fraud-and-abuse.aspx
[12] See GAO's work on Reducing Government-wide Improper Payments, available online here: https://www.gao.gov/key_issues/reducing_government-wide_improper_payments/issue_summary#t=0
[13] See the National Association of Medicaid Directors, Legislative Priorities, available online here: http://medicaiddirectors.org/wp-content/uploads/2016/12/NAMD-Legislative-Top-Issues-for-2017_FINAL.pdf

Last year, the House passed the American Health Care Act (AHCA) that included putting a per capita cap on Medicaid. The policy idea behind a Medicaid per-capita cap is that the Federal government would continue to provide matching funds for each individual enrolled in a State's Medicaid program, but unlike in the current arrangement, the Federal government would set a limit on the maximum allowable amount per enrollee. There would be spending limits per State in each of the main Medicaid eligibility groups: the elderly, people with disabilities, children, and nondisabled, nonelderly adults. These caps would be based on each State's historical average cost for an enrollee in each eligibility group.

As former Committee Chairman Henry Waxman explained at a 1996 Congressional Hearing, under a per capita cap reform, "the [F]ederal government would maintain its commitment to sharing in the costs of providing basic health and long-term care coverage to vulnerable Americans." He correctly pointed out that "[S]tates would have both the incentives and the tools to manage Medicaid more efficiently," and the continued Federal commitment would help "when [S]tates face cost increases for reasons beyond their control, including recessions, regional economic downturns, natural disasters, and outbreaks of contagious disease."

Modernizing Medicaid's financing by putting the program on a budget is not draconian, just common sense. If more spending and more government were the answer, Medicaid patients would have access to world-class health care. Yet, research from an array of scholars has shown that too few providers accept Medicaid patients to meet existing needs, and that Medicaid coverage often fails to improve health outcomes for many patients. We must focus on modernizing this Great Society program, so it can offer real access to providers and improved health outcomes for decades to come. Working together with governors and State Medicaid reformers, we can empower States with new statutory flexibilities. We can modernize the waiver process, so States can focus on managing their programs based on the needs of their patients, not managing paperwork for CMS. We can create better tools and incentives for States to reduce costs, boost quality and improve health outcomes.

Administration's goal of lowering drug prices and proposed rules on the issue:

The Administration has proposed significant rules that would impact the price of drugs. For example, the proposed rebate rule put forward by HHS on January 31, 2019, would, for the Medicare Part D and Medicaid managed care programs, remove the safe harbor exemption for rebates applied after the point-of-sale and establish a new safe harbor that would enable a pharmaceutical manufacturer to offer reduced prices on a prescription pharmaceutical product (referred to as chargeback discounts) when they are applied at the point-of-sale. This hearing is a good opportunity to discuss this proposed rule, and others, with Secretary Azar and determine what sort of impact the rule would have on drug prices.

New Commercial Health Insurance Options:

The Trump Administration has taken several legislative and administrative actions to increase patient choice, enhance State flexibility, and more efficiently utilize tax resources.

These actions include eliminating Obamacare's tax penalty for the unconstitutional individual mandate, allowing more small businesses to form Association Health Plans (AHPs) to provide more affordable health insurance choices, and expanding short-term, limited-duration insurance (STLDI) plans. The Council of Economic Advisors recently projected these reforms to expand consumer options will generate $450 billion in benefits to Americans over the next decade.

Association Health Plans:

The Trump Administration has permitted workers and small businesses to pool together to buy insurance through Association Health Plans (AHPs) to increase their purchasing power. Many of these plans comply with Obamacare's coverage mandates, meaning they are not charging people different premiums based on their health conditions, and they are not banning people with pre-existing conditions from enrolling. Additionally, plan sponsors have made statements that the coverage includes comprehensive benefits, broad networks, and lower premiums than those available on the Obamacare exchanges. Employers across the country are already taking advantage of this option to provide more affordable insurance to their workers. Twenty-eight AHPs have formed already, with some showing up to 30 percent savings on premiums. The Las Vegas Chamber of Commerce is in the process of signing up 500 employers for an AHP, which could save some employees more than $2,000 per year.

Short-Term, Limited-Duration Insurance:

In coordination with the Department of Labor and the Department of the Treasury, HHS revised the Obama Administration regulations limiting STLDI plans from 12-months to three months by allowing the plans to be available to consumers for up to 364 days and renewable up to 36 months.[14]

The Trump Administration regulation aims to provide relief from rising premiums and expand access affordable health care plans. According to CMS, "[i]n the fourth quarter of 2016, a short-term, limited-duration policy cost approximately $124 a month compared to $393 for an unsubsidized ACA-compliant plan."[15] The Administration projected roughly 100,000 to 200,000 individuals would move from PPACA-compliant plans to STLDI. These more affordable plans may be attractive options for individuals who are between jobs, cannot afford PPACA coverage, or cannot see their doctor because they are out of network.

IV. REPUBLICAN STAFF CONTACTS

If you have any questions regarding this hearing, please contact J.P. Paluskiewicz or Adam Buckalew of the Republican Committee staff at (202) 225-3641.

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[14] 26 CFR Part 54, 29 CFR Part 2590, 45 CFR Parts 144, 146, and 148

[15] Centers for Medicare and Medicaid Services. "Fact Sheet: Short-Term, Limited-Duration Insurance Proposed Rule." February 20, 2018. https://www.cms.gov/newsroom/fact-sheets/fact-sheet-short-term-limited-duration-insurance-proposed-rule.